MassHealth

The Commonwealth of Massachusetts
Executive Office of Health and Human Services

MASSHEALTH HOSPICE FORM

Instructions

Whenever a MassHealth member, including a member in a nursing facility with both Medicare and MassHealth coverage, wishes to elect hospice services, revoke hospice services, or change the designated hospice, the hospice must complete this form and submit it to MassHealth (see 130 CMR 437.412). MassHealth will not pay for hospice services unless a completed form has been submitted. Complete Section A below and either Section B (Hospice Election), Section C (Hospice Revocation), or Section D (Hospice Change). The member or the member's representative must sign this form when electing or revoking hospice services or when changing hospices.

MassHealth Managed Care Organization (MCO) Members: MassHealth MCO members who elect hospice services by signing this form will be automatically disenrolled from their MCO.

Effective Date: In accordance with 130 CMR 437.412 and 437.424, the effective date for reimbursement of hospice services is the effective date entered on the hospice form submitted to MassHealth. The effective date for hospice services may not be earlier than the date the member or the member's representative signs this form.

Mail the completed form to the following address.

EOHHS
MassHealth Benefit Coordination and Recovery Unit/Hospice Program
600 Washington Street
Boston, MA 02111

Section A: Hospice and Member Information *(Required)*

Hospice Name: _____

Hospice Address: _____

_____

MassHealth Member Name: _____

Member Address: _____

_____

MassHealth Provider No.: _____

Hospice Telephone No.: _____

MassHealth Member ID: _____

Member Diagnosis: _____

Section B: Hospice Election *(Check here when choosing hospice services.)* ☐

Effective Date of Hospice Election: _____

Member Statement: I agree to get all care for my terminal illness from the hospice named above. I know that hospice services are for my care and comfort, not for curing me. I understand that unless I sign a form to stop hospice services, I have to get all care for my terminal illness from the hospice.

_____ _____

Signature of Member or Member's Representative *Date*

Section C: Hospice Revocation *(Check here when stopping hospice services.)* ☐

Effective Date of Hospice Revocation: _____

Member Statement: I want to stop getting hospice services and get my regular MassHealth benefits again. I know that by signing this, MassHealth will not pay for hospice services for me for the rest of my current hospice election period. I can still get hospice coverage later if I sign up again.

_____ _____

Signature of Member or Member's Representative *Date*

Section D: Hospice Change *(Check here when changing hospice providers.)* ☐

The **originally designated hospice** must complete Section A and Section D, Part 1 only, of this form and submit it to MassHealth. The signature of the member or the member's representative is ***not*** required.

The **newly designated hospice** must complete Section A and all of Section D of this form, **including** the dated signature of the member or the member's representative, and submit it to MassHealth.

Part 1

Effective Date of Hospice Change: _____

Part 2

Member Statement: I want to change to a different hospice provider. The hospice provider I have now is:

_____

The hospice provider I want to change to is:

_____

_____ _____

Signature of Member or Member's Representative *Date*